Advanced certification next

Hospital Sails over Heart Failure Certification Bar

About two dozen UCH administrative and clinical leaders arranged themselves around the long table in the 10th floor Leprino Building boardroom April 24. At the head of the table sat Joint Commission reviewer Reggie Madden. He was about to pass judgment on the hospital’s Heart Failure Program, based on his one-day visit.

The two-year heart failure certification would be the hospital’s first. It would show that the program meets clinical performance measures and provides the broad range of patient care necessary to improve outcomes for patients whose hearts lose their ability to pump blood in sufficient quantities to the rest of the body.

“You are one of the best in the country at taking care of heart failure patients,” Madden said. “I’m very much impressed with the level of commitment. There are no areas of weakness.”

As the crowd relaxed, Madden ticked off the many program strengths he observed during his visit: consistent use of order sets by team members, strong team leadership, well-organized delivery of patient care and a commitment to evidence-based practice.

Why not more? Then he posed a question. Why, he asked, had the program not tried for advanced certification? “You have all the pieces in place to go for it,” he said. “You are ready, and hopefully will be seeking it next year.”

“Why not more?” Prutzman, RN, MSN, UCH’s executive director of Cardiac and Vascular Services, said later. But she added, “We have to crawl before we can walk.”

Pruzman said the hospital had only recently applied for disease-specific certification in heart failure when the Joint Commission announced last May that it was adding an advanced certification level to programs that demonstrate they can successfully and safely transition heart failure patients from the inpatient to the outpatient setting.

“We’ll go for the advanced certification the next time around,” said Prutzman, noting there is only one other hospital in the metro area – Swedish Medical Center – that has it.

Looming changes. The Joint Commission certification aside, the hospital is already focused on transitions of care for heart failure patients and intends to increase its efforts as it prepares for upcoming reimbursement changes announced by the Centers for Medicare and Medicaid Services (CMS).

Beginning this October, hospitals that exceed average 30-day readmission rates for patients admitted with a primary diagnosis of heart failure, pneumonia or acute myocardial infarction would lose 1 percent of their total Medicare reimbursement. The amount is slated to rise to 3 percent in 2014 (Insider, Oct. 14, 2010).

In 2010, the hospital joined a nationwide effort to reduce heart failure readmissions, co-sponsored by the Institute for Healthcare Improvement and the American College of Cardiology (Insider, June 24, 2010). The program, dubbed “Hospital to Home,” focuses on medication management, symptom management and early follow-up as essential to keeping heart failure patients from coming back in 30 days or less.

A large, multidisciplinary task force at UCH helps to coordinate the effort (see box). The “H2H” team has helped the hospital standardize the care it delivers heart-failure patients, Prutzman said, a key to reducing readmissions.

Also on the horizon are “bundled payments,” whereby CMS will pay hospitals a certain amount for all the services it provides to manage a single illness, “or episode of care.” Heart failure is a targeted condition; the hospital is exploring how to coordinate services to be successful in a bundled-payment system in which consistent care and follow-up will be keys to success, Prutzman noted.

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Improvement opportunities. Meanwhile, Prutzman said the program will continue to work on strengthening some other areas:

» Delivering education about heart failure and how to recognize its signs and symptoms to nursing staff and physicians across the hospital.

» Encouraging staff to use admission and discharge orders for heart failure patients consistently.

» Improving community and patient education.

» Creating an internal campaign to raise awareness about the disease. “Everybody should be informed that heart failure patients are a major population that we care for and aware of the guidelines for recognizing it and the order sets for treating it,” Prutzman said.

» Soliciting patient feedback. Madden noted two conversations he had with patients who favorably assessed the program, but he urged the hospital to “get information at all levels. You could do that at discharge or with a three-day follow-up. But identify ways to improve.”

Both Madden and Prutzman emphasized the need to ensure that patients admitted anywhere in the hospital receive the same level of care delivered by providers with the Heart Failure service. Two-thirds of heart failure patients, Prutzman said, are admitted either through general cardiology or other medical units to be treated for other issues. The symptoms of heart failure—fatigue, shortness of breath—may be difficult for physicians and nurses to sort out in terms of underlying causes.

“We have to figure out how to give special training so providers in all departments loop patients into the Heart Failure Program,” Prutzman said. –Tyler Smith

H2H Heart Failure Task Force Members

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